Gentle Family Dentistry

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Dunkirk, MD 20754

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(410) 257-2424

I understand that, under the Health Insurance Portability and Accountability Act of, 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change their Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient’s Name (Print): ____

Responsible Party’s Relationship to Patient: ____

Responsible Party’s Name (Print): ____

Responsible Party’s Signature: _______________________________________ Date: _____________

Office Use Only

I attempted to obtain the parent’s signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason: ____

Date: _________________ Initial: ____________________